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THE A-B SCALE: PERSONALITY CORRELATES IN PSYCHOTHERAPY

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THE A-B SCALE: PERSONALITY CORRELATES IN PSYCHOTHERAPY

CHAPTER I

INTRODUCTION

The human relationship between client and therapist is central to contemporary conceptions of psychotherapy. The basic problem involved in psychotherapy is an effort on the part of one of two individuals, the therapist, to create an atmosphere in which the other person, the client, can realize a constructive emotional learning experience through his interpersonal relationship with the therapist. This study is an attempt to investigate one aspect of this relationship, the behavior of the psychotherapist, and to determine how it is correlated with the A-B Scale, an instrument which has been shown to be related to therapeutic effectiveness.

For some time the issue of the contribution of the therapist's personal characteristics to the process of psychotherapy was of little concern to many psychotherapists. Most of the early practitioners of psychotherapy based their thinking about the process of psychotherapy on the theories advanced by Sigmund Freud, who gave little emphasis to the personal qualities of the therapist, focusing instead on the technical contributions. Freud conceived of the analyst's role in the therapeutic process as that of a "blank screen." According to the "guide

lines" established by Freud, the therapist is to behave in an impersonal, non-evaluative, and objective manner in order to aid the patient to find release for unconscious thoughts. But it is difficult to imagine how the therapist, who is a person with his own feelings, attitudes, conflicts, and life experiences, can remain a blank screen while associating with patients over long periods of time. Freud (1953) was aware, however, that the personality of the therapist might play an important part in the treatment process; he formulated the concept of counter-transference, which refers to obstacles to therapy which could be contributed by the therapist's personality. His recommendation of a training analysis for all psychoanalysts was his attempt to eliminate, as far as possible, adverse influences arising from the therapist's personality attributes. Freud did not consider that the therapist's personality might have a positive effect.

Freud's concept of counter-transference impeded exploration of the significance of the therapist's personality on the course of therapy for about 30 years after its introduction (Alexander, 1963). Even to this day, traditional psychoanalytic practitioners "adhere to the concept of the psychotherapeutic situation not as the relationship between two participants but as the analysand's relationship to the analyst" (Strupp, 1962). This adherence to the impersonal role of the therapist contributed to create a theoretical vacuum, in that no conceptual framework is available for thinking about the therapist's influence on the therapeutic process.

More recently, however, there has been a shift in theoretical orientations in the direction of attempting to conceptualize the therapist as at liberty to use his person more freely and directly as a

therapeutic force. As a result of this shift in orientation the personal attributes of the therapist have come to be looked on as an important therapeutic agent. The interpersonal aspects of the therapeutic relationship is given significant attention in the writings of Alexander (1963), Fromm-Reichman (1950), Horney (1965), Rank (1945), Sullivan (1953), and Thompson (1950), and more recently by Rogers (1957) and Truax (1966). Although some theoretical differences exist between these contemporary viewpoints, there is general agreement that the therapist's personality is an important factor in the treatment process. Taft (1933), in expounding the theories of Otto Rank, stressed heavily that the therapist as a unique individual is a significant variable in the psychotherapeutic relationship. She wrote that "the basis of therapy lies in the therapist himself, in his capacity to permit use of self which the therapeutic relationship implies as well as his psychological insight and technical skill" (p. 19). Strupp (1960), from one of his many investigations of behavior of psychotherapists in experimental therapeutic situations, also formed the opinion that the therapist's contribution is both personal and technical. He believes that personal aspects probably represent a sine qua non, whose effects may be deepened and maximized by appropriate technical operations. More recently Stone and Wilson (1965) also took cognizance that technical operations and personality factors interact and affect the treatment process. Alexander (1963) is also of the opinion that the therapist, by virtue of the fact that he is an individual, facilitates the patient achieving a "corrective emotional experience."

The emerging recognition that the therapist is an active participant stimulated interest in learning how he may affect the therapeutic

process. One of the avenues of pursuit centers around the investigation of the therapist's expectations as a determinant of therapeutic outcome. Frieda Fromm-Reichmann (1950) was one of the first to express the notion that the therapist's own belief about his client's prognosis could be a determinant of that prognosis. Both Verplanck (1955) and Goldstein (1962) have pointed out that it is possible that therapeutic rehabilitation may be a function of the client's response to the therapist's expectations or wishes. More recently, the work by Orne (1962; 1962a) on the concept of "demand characteristics," which explores the role of the experimenter (therapist) as a determinant of any results obtained from his interaction with subjects (clients), also suggests that therapist's expectations are a significant factor in how therapy progresses. According to this concept, changes in the client's behavior during therapy are directly related to the intentional, and unintentional, influence or suggestion of the therapist. Krasner (1966) believes that in a therapeutic relationship the therapist deliberately creates demand characteristics to stimulate changes in the client's behavior. In another series of important research which also illustrates that one individual (experimenter or therapist) can influence another's behavior, Rosenthal (1963; 1963a) has demonstrated that experimenters with an established bias could affect how a subject responds to various tests. In one of his studies, for example, he has shown that experimenters with an established bias could significantly affect subjects' pattern of responding to the Minnesota Multiphasic Personality Inventory (1963). Lord (1950) attained a similar shift in a subject's performance on the Rorschach test. Other research in the area of assessment of personality has also shown that the personality and behavior of the assessor (or observer or therapist) can

affect the response or behavior of the person with which they are interacting (Masling, 1960; McGuigan, 1961; Mulry, 1962; and Pflugrath, 1962). It has also been demonstrated that the interviewer in a public opinion survey can have a significant affect upon his respondent (Hyman, Cobb, Feldman, Hart, and Stenber, 1954). Findings such as these would seem to support clearly the notion that the therapist as a person, with his unique personality characteristics, can significantly affect the course and outcome of treatment.

With the awareness that the therapist can influence the psychotherapeutic relationship, the issue becomes one of attempting to discover how he may do so. Raush and Bordin (1957) advanced the belief that the therapist's warmth is a significant factor in psychotherapy, and that it is of greater importance than the therapist's "commitment," "effort to understand," and "spontaneity." Rogers (1967) speaks of the therapist's "genuineness in the relationship," and of his "unconditional positive regard," and "empathy" as being necessary conditions for psychotherapy to progress. Other researchers such as Apfelbaum (1958), Fiedler (1950; 1950a; 1953), Lorr (1965), and McNair, Lorr, and Callahan (1963), have advanced the notion that the therapist's ability to accept and understand the client is a significant factor. Frank (1959) presents the hypothesis that the client's attitude of trust or faith in the psychotherapist may play a significant part in the client's response to all forms of psychotherapy. Frank believes that this favorable expectation from the client is fostered by the therapist's own confidence in his ability to help, by his caring deeply about the client, and by his being able to communicate these successfully. Wallach and Strupp

(1964) also emphasize the importance of the therapist's personal involvement in the therapeutic relationship.

Although the therapist can exert considerable influence on the process of psychotherapy, the outcome of therapy is also dependent upon the personality characteristics of both the therapist and client in interaction. Stated in another way, "The effect of certain patient or therapist characteristics upon outcome is dependent upon the particular characteristics of the other member of the dyad" (Carson and Heine, 1964, p. 426). Such an effect has been demonstrated empirically in several recent investigations (Carson and Heine, 1962; Cartwright and Lerner, 1963; Hiller, 1958; and Pfours and Rader, 1962). These findings would appear to support the theory (Orne, 1962) that the demand characteristics of a situation, that is, the impact of one individual on the other as they interact, is an important variable to be studied as it applies to the therapeutic relationship.

The question as to the nature of specific therapist influences affecting the therapist-client interaction is obviously basic to an understanding of the therapeutic process, and has far reaching implications for all forms of interpersonal learning, as well as education, child rearing, and interpersonal perception, to name but a few areas of application.

Research data about the nature of the therapist's influence of specific effects on the psychotherapeutic relationship has recently begun to accumulate. An important contribution of empirical research findings related to this problem has been provided by Whitehorn and Betz (1954; 1960). After analyzing the records of one hundred schizo-

phrenic patients to assess therapeutic progress, these authors isolated one group of therapists (called Group "A"), whose patients had a high improvement rate (36 out of 48 - 75%), and another group (called Group "B"), who were less successful (14 out of 52 patients - 26.9%). From further study of the therapist constituting these two groups it was discovered that they could be differentiated on the basis of their responses to twenty-three items from the Strong Vocational Interest Blank (see Table 1). These twenty-three items have come to be known as the Whitehorn-Betz A-B Scale. On the basis of these differences Whitehorn and Betz were able to predict therapeutic effectiveness prior to the therapist's actual contact with patients. Whitehorn and Betz succeeded in replicating and cross-validating their findings (summarized by Betz, 1962).

Since the following conditions prevailed in their investigation: (1) prediction of effectiveness prior to therapists' contact with patients, (2) relative homogeneity among the therapists with regard to training, theoretical orientation, and experience, and (3) no significant clinical and demographical differences between the patients of A's and B's, it is possible to conclude that the A-B Scale measures some aspect of the therapist's personality which is related to success in treating schizophrenic patients. The A-B Scale represents, then, the first personality measure which has been predictive of the therapeutic success. Research in psychotherapy has been hampered by the lack of such a measure. This scale appears to have potential to fill this void.

Whitehorn and Betz concluded, from their study of chart notes of A and B therapists, that the more successful therapists (A's) could be

TABLE 1

Strong Vocational Interest Blank Items (Form M)
which Discriminated between A and B Therapists

<u>SVIB Number</u>	<u>Description of Item</u>
17	Building Contractor. (D, I) ^a
19	Carpenter. (D, I)
59	Marine Engineer. (D)
60	Mechanical Engineer. (D)
68	Photoengraver. (D)
87	Ship Officer. (D, I)
90	Speciality Salesman. (D)
94	Toolmaker. (D)
121	Manual Training. (D, I)
122	Mechanical Training. (D, I)
151	Drilling in a company. (L, I)
187	Adjusting a carburetor. (D, I)
189	Cabinet making. (D, I)
216	Entertaining others. (D, I)
218	Looking at shop windows. (D, I)
290	Interested public in a new machine through public address. (L, I)
311	President of a society or club. (L)
365	Having many women friends.
367	I can accept just criticism without getting sore. (Yes)
368	I have mechanical ingenuity. (No)
375	I can correct others without giving offense. (Yes)
381	I can follow up subordinates effectively. (?, Yes)

^aResponses of A therapists are indicated in parenthesis following each item: L = like, I = indifferent, D = dislike. Where two choices are indicated, A's responded by selecting either "D" or "I." From Whitehorn and Betz, 1960.

characterized as (1) having a better understanding of the meaning and motivations of the patient's behavior, (2) tending to be more perceptive of the inner experience of the patient, (3) to regard the patient as an individual whose solutions to his problems are obtained through collaborative efforts, and (4) to "expect and respect spontaneity," and to "evoke self-respectful social participation" more successfully than therapists in group B. In contrast, the less successful therapists (B's) were described by Whitehorn and Betz as placing greater emphasis on "regulatory or coercive" efforts, and to focus on symptom reduction and encouragement of "better socialization." These findings were interpreted by Whitehorn and Betz to mean that in the treatment of schizophrenic patients, those therapists who are more successful succeeded in establishing a personal relationship characterized by trust and confidence, and that they are more "active" in helping the patient to reorient himself in his personal relationships.

In reviewing Whitehorn and Betz' findings and conclusions, however, one should be aware that the characterization of the two groups of therapists is based on assessment of case records completed by the therapist; that is, the physician's own description and impressions of the way in which he perceived and noted the progress of his cases. Thus, Whitehorn and Betz may have acquired data about how their two groups of therapists perceived and summarized their work in therapy, rather than having obtained information about how they actually conducted therapy. Nevertheless, their findings apparently provide some clues about what personality characteristics of the therapist may be related to therapeutic effectiveness, particularly since they have succeeded in cross-

validating their original findings. Whitehorn and Betz may have also provided a measure, The A-B Scale, through which it seems possible to assess personality differences between therapists.

The A-B Scale has subsequently been used in a variety of investigations to confirm its predictive power and to seek its personality correlates. These studies may be categorized into three areas: (1) psychotherapy outcome (McNair et al., 1962), (2) attitudes of A and B individuals toward patients (Kemp, 1963; Kemp and Sherman, 1965; Carson and Klein, 1965), and (3) behavioral correlates of A's and B's in interpersonal situations (Carson, Hardin, and Shows, 1964).

McNair, et al. (1962) attempted to replicate Whitehorn and Betz' findings with a sample of therapists treating non-schizophrenic patients. Contrary to expectations, patients of B-type therapists showed significantly greater improvement. Although these results are opposite to those of Whitehorn and Betz, they are confirmative of a relationship between the A-B Scale and therapeutic outcome. These findings also suggest that this relationship involves a complicated interaction between patient attributes, improvement, and therapist personality characteristics. Specifically, it is possible to conclude that A-type therapists are more effective with schizophrenic patients than with non-schizophrenic patients, and that the converse hold for B-type therapists.

Further studies have confirmed such an interactive relationship. Kemp (1963) attempted to determine if persons classified as A's or B's would respond differently to subjects behaving in accordance with

"experimentally standardized personality characteristics." His subject-patients were characterized by having symptomatology which was predominately either "turning-against-self" (neurotic) or "avoidance-of-others" (schizoid). The results showed a significant "therapist-type" by "patient-type" interaction in regard to the level of discomfort and ease in responding to these two types of patients. The A's were less comfortable and had greater difficulty in responding to the schizoid-type subjects, while B's responded in the same manner to neurotic patients. These findings reiterate previous findings that A's and B's are individuals who are in some way differentially sensitive to differing forms of behavior pathology.

Carson, et al. (1964), in following up the implications from Kemp's investigation, have reported two experiments whose results also show that A's and B's respond differently to persons portraying differing forms of behavior pathology. In the first of these experiments A's and B's responded to letters purported to have been written by patients in a local mental hospital. These letters were composed in such a way as to be written by patients characterized by either one of the three following syndromes: (1) avoiding-others (Ao), (2) turning-against-self (As) and (3) turning-against-others (To). It was found that A's were more likely than B's to respond to patients with either Ao or To symptoms by "interpreting more deeply and directly," while B's tended to respond to As patients with a greater degree of "depth directedness" than A's.

In the second experiment reported by Carson et al. (1964), the task of the A and B subjects was to interview students who were induced

to maintain a particular "set" toward their interviewer. This set was established by prewarning some of the respondents that they could expect a "cagey," "cunning" interviewer who would resort to "trickery," and by telling other interviewees that their interviewer would be a "direct and sincere" type of individual who would take a "real interest in people." As was predicted, A interviewers tended to get relatively more information from subjects "set" for distrustful interviewers and B's from respondents "set" for a trusting interviewer. Carson, et al., offered the following tentative conclusions:

A's in relation to persons exhibiting distrustful-extrapunitive behavior, and B's in relation to persons exhibiting trusting-intropunitive behavior are (relative to the opposite conditions) more sensitized and alerted to, and at the same time more capable of understanding and formulating what the other person is saying and doing; given these circumstances they are prompted to assume a relatively more leading, assertive role when the structural nature of the relationship permits that form of adaptation (pp. 432-433).

In a further extension of the study by Carson, et al. (1964), Carson and Hardin (1964) attempted to focus on the actual behavior of A- and B-type subjects in the interview situation. No significant differences were obtained between A's and B's pertaining to their kinds of "interpersonal behavior" (which may be due to low rater reliability). But the results indicated that A's in relation to the distrustful, hostile, expectancy of harm (schizoid) interviewees, and B's in relation to the trustful, friendly, expectancy of help (neurotic) interviewees (relative to the opposite conditions), tended to be more broadly ranging in their exploratory activity and to perceive their partners as more flexible, and to be perceived by their partners as favoring a more dominant role.

More recently, Carson and Klein (1965) attempted to clarify and explore further the suggestion from previous studies that A- and B- persons are in some way tuned to respond differently "to a component variable of a role partner's behavior" (p. 2). They found an interaction between A- and B-type persons and interviewees portraying different symptoms. In describing this interaction, Carson and Klein report that A's, in relation to the avoiding-others (Ao) type of subject, and that B's, in relation to turning-against-self (As) behavior, attributed to the interviewees, in a relative sense: (a) less cooperativeness, (b) more cruelty, meanness, (c) more imaginativeness, (d) more laziness, (e) less likableness, (f) less reserve or dignity, and (g) less of a sense of humor. Thus, B's tended to see the As subject, and the A's the Ao subject, in relatively negative terms. Similar results are reported by Kemp and Sherman (1965). They found that A's, in evaluating schizoid patients, and B's, in evaluating neurotic patients, (1) were less interested in treating the patient; (2) had less confidence in the outcome of treatment; (3) perceived the patient as being less like their concept of an ideal patient; and (4) believed that it would be more difficult to discover the etiology of the patient's illness.

In summarizing the A-B research reported thus far it is apparent that A and B individuals are reacting differently to people with or portraying differing forms of behavior pathology. Specifically, A's have been shown to respond to "schizoid" symptoms, and B's to "neurotic" symptoms, with negative attitudes or reactions, yet with apparent greater effectiveness. But there is not yet an understanding about what underlies this differential reaction, that is, little is known about

the personality characteristics of A's and B's which may contribute to the nature of their different interaction with schizoid or neurotic forms of behavior.

A recent study by Segal (1966) provides some preliminary information as to what kinds of people A's and B's might be. After evaluating interview data obtained from medical students classified as A's or B's on the basis of their extreme scores on the A-B Scale, Segal found some differences between the A and B groups of subjects. The most pervasive and outstanding difference was that as a group the A subjects tended to show more interest in other people than did B subjects. The A's were also observed to be more "other directed" and more gregarious than B's. The B's tended to show greater interest in "things" than people, such as preferring to work with their hands rather than engage in social activities. Another difference was that the A subjects tended to be more susceptible to influence from others. For example, four out of five A subjects reported that they chose medicine as a profession because they were influenced by another person. None of the B subjects stated that they were influenced in any manner by others in selecting medicine as a career. Further, Segal found that all the A subjects described themselves as being interested in understanding and learning about the nature of diseases and in the diagnostic process. None of the B's stated this interest. The A's, as a group, tended to be more interested in problem solving or deductive reasoning than B subjects, who tended to focus more on concrete reality and less on reasoning things out. The B subjects also tended to be more critical of things than A's, as well as more specific in expressing their likes and dislikes.

This finding of an apparent difference in sociability between A and B individuals suggests some hypotheses about what may be underlying their differential reaction to persons with different types of disorders. It appears possible that the negative evaluation of the avoiding-other (schizoid) individual by A's, and the negative evaluation of turning-against-self (neurotic) persons by B's, may be based on how they characteristically relate to others. The A individual, who is presumably interested in others and "outgoing," may not respond positively, and might even dislike a person who tends to avoid others, while B's, who are apparently less "outgoing" than A's, may not react favorably to persons they perceive to be somewhat like themselves. The striking thing, however, as noted above, is that under conditions in which an A is placed with an Ao person, and B with an As person, the result is an apparently more effective working relationship between these pairs. Further investigation is needed, however, to gain an increased understanding of the fundamental differences between A's and B's, and to determine how these differences are related to the ways in which they interact in a psychotherapeutic relationship. It is the latter issue with which this study is concerned.

This review has indicated that the A-B Scale has been repeatedly linked directly to psychotherapy or psychotherapeutically-relevant interpersonal processes. As such it clearly appears to be a measure of personality attributes, which are related to performance in psychotherapy. Further identification and exploration of the personality correlates of the A-B Scale, and how they are manifested in psychotherapy, would help to provide information about the little understood relation-

ship between the therapist's personal qualities and his therapeutic style. Such information would provide an empirically derived measure which could be used for classifying therapists along different levels of a dimension in order to obtain experimental groups for psychotherapy research. As Kiesler (1966) states:

. . . if psychotherapy is to progress, it seems essential that theoreticians and/or investigators first define therapist behavior in precise terms; by specifying the exact interrelations among these dimensions . . . and by specifying their differentiations for various kinds of levels of patients (p. 127).

Such information might also lead to a means of matching therapists and clients in order to increase the likelihood of a successful outcome. A means of predicting the degree of compatibility between patient and doctor, according to the Joint Commission of Mental Health (1961), is urgently needed. They report that many individuals go untreated because they are a class of persons lacking human appeal and who are "humanly rejected because of this lack of appeal" (p. 86). The Commission is referring to the chronic psychotically ill person, namely the schizophrenic patient, who is often

harmed by the process of rejection that reaches its epitome in the traditional state hospital system. Both he and his fellow man appear generally unaware of their pantomime of action and reaction, provocation and retaliation, leading increasingly to his alienation from society (pp. 86-87).

But it is known that many of these people are not beyond help and often turn to others for help; and if received they are usually responsive to such help (see for example, Hayward and Taylor, 1956). The problem is one of finding people to work with and respond to this type of mentally ill individual. If greater effectiveness in treating the chronically ill is attained, then this may in turn help change public opinion to a

more acceptable and optimistic view concerning mental illness and its treatment, particularly for the seriously disturbed and chronically ill mental patient. Thus, it seems important to not only understand more about the process of psychotherapy, but to use this information practically to work with people. It would seem that further exploration of the A-B Scale might be potentially fruitful to not only help identify therapist-patient compatibility in the "helping process," but to also gain further understanding about the process of psychotherapy and some of the psychotherapeutic agents which may mediate success.

CHAPTER II

STATEMENT OF THE PROBLEM

The A-B Scale appears to be a means for understanding the psychotherapeutic process. It has been shown to be a measure which predicts behavior in a variety of contexts that have direct implications for psychotherapeutic processes (Carson, 1966). There is, however, no knowledge yet accumulated as to how A-B personality correlates are related to behavior in therapy. Thus, the basic question remains: How do A's and B's differ in their practice of psychotherapy? Prior studies of the A-B Scale have been concerned with either therapeutic outcome or the attitudes of therapists toward clients. Moreover, except for the original studies by Whitehorn and Betz (1954; 1960), and the one by McNair et al. (1962) none of the other research with the A-B Scale reported thus far was conducted in actual clinical situations. All made use of therapeutic analogues or quasi-therapeutic situations, using non-professionally trained individuals as subject-therapists. One of the questions with which this study is concerned is how the reported findings pertaining to the A-B therapist distinction are manifested in actual psychotherapeutic situations.

It is expected that the behavior of A- and B-therapists will vary sufficiently to permit reliable differentiation of their respective therapeutic activities. Given appropriate criteria for measurement of

therapist activity, then the various activities of a single therapist or groups of therapists can be compared as to kinds of therapeutic interaction. This investigation will focus on the therapist's communications, and attempt to classify them into discrete categories in order to compare and contrast therapeutic activity.

In order to approach the problem of analyzing therapist verbalizations a system of content analysis has been devised to abstract certain salient features from the verbal behavior of the therapists. Content analysis of process is a method of characterizing, according to the dimensions of the content-analysis system used, the actual nature of the therapist's verbalizations. Content analysis studies of psychotherapy have been used with apparent success by Strupp (1955; 1960), Cutler (1958), Holzman and Forman (1966), and Lennard and Bernstein (1960), among others.

In attempting to determine if the Whitehorn-Betz A-B Scale differentiates between two "types" of therapists who interact in a different manner with their respective clients, the scope of this study will be limited to comparing therapeutic activity of A's and B's with clients presenting similar basic characteristics or behavior (neurotic or turning-against-self symptoms).

The basic hypothesis of this research is that there is a relationship between therapist's scores on the A-B Scale and their Therapeutic behavior. Specifically, this investigation is attempting to determine if there are differences in therapeutic activity with regard to (1) attitude toward clients, as manifested by their verbalizations, (2) type of therapeutic activity (questioning vs. interpretative state-

ments), and (3) specificity of statements (the degree to which the therapist's comments set limits on the range of possible alternatives from which the client may select his reply).

CHAPTER III

METHOD

SUBJECTS

Twenty male graduate students in a clinical psychology training program constituted the subjects for this investigation. These therapists range in age from 23 to 45 years, with a median age of 28.5 years. Ten were advanced students, having had internships in various professional settings. The remainder of the therapists were pre-doctoral candidates, not yet having completed general examinations or an internship. Their mean experience in psychotherapy training is 2.7 years, with a range of one to 6.5 years. All therapists, since they are known to this experimenter, and are in the same training program, are regarded to be homogeneous in regard to theoretical orientation. The A-B scores obtained from these therapists ranged from 6 to 19, with a median score of 13.5. These A-B scores were derived from their responses to the original 23 items on the Strong Vocational Interest Blank, on which the therapists in Whitehorn and Betz' (1954) initial study were found to differ (see Table 1). The differentiation of A's from B's may be obtained by assigning a score of one for the items checked which are consistent with the ones found representative of A's and a zero for the items checked representative of B's. Scores can range from a low of zero, representative

of B's, to a high of 23, the A-end of the continuum. If desirable, designation of A and B groups may be obtained by splitting the scores at the median.

The client population consisted of 13 males and 7 females, who range in duration of treatment from one month to two years, with an average time in treatment of 9.5 months. The ages of the clients range from 18 to 45 years, with a mean of 28.5 years. Selection of client-therapist dyads was made on the basis of how each was described on the Symptomatic Behavior Inventory Rating Scale. This measure is derived from the classification scheme used by Phillips and Rabinovitch (1958), to determine whether a person's primary mode of functioning is characterized by a neurotic (turning-against-self) or schizoid (turning-against-others) type of adjustment (see Appendix B for a copy of this Scale). This Scale is the measure used in previous A-B studies to characterize client behavior. After evaluating the Behavior Inventory for each of the clients being seen in therapy by all the psychotherapists in this study, the person who most closely resembled or presented symptoms congruent with neurotic or turning-against-self behavior was selected as the other member of the therapeutic dyad, and this relationship was the one studied.

PROCEDURE

Each therapist completed the A-B Scale, and also filled out the Symptomatic Behavior Inventory for each person he was seeing in a therapeutic relationship. Two tape recordings of the selected therapeutic relationship, with a minimum of two weeks between recordings, were

obtained from each of the therapists. Tape recordings are routinely obtained by therapists for supervision purposes by having a tape recorder in the room during any given hour. Therefore, the obtaining of these two recordings should not have presented any atypical circumstances. The therapists, however, were unaware as to the purpose of why the tapes were requested. It was decided to evaluate two therapeutic interactions in order to obtain a greater representation of therapeutic activity, and to check on the consistency of therapist activity. A typed transcript of the therapist's verbalizations for each of the two therapy hours was then derived. These transcripts are the source of the data being evaluated in this study.

EVALUATION OF THERAPIST VERBALIZATIONS:
CONTENT ANALYSIS SYSTEM

Three content analysis systems were applied to these data:

(1) The Interaction Process Categories (Bales, 1950), (2) Therapist Directiveness, a measure adapted from Strupp's (1960) Measures for Analyzing Psychotherapeutic Interactions, and (3) Therapist Specificity, adapted from Lennard and Bernstein's (1960) Categories for Evaluating Psychotherapy. These Scales have been used extensively in psychotherapy research and shown to be reliable measures, capable of yielding optimally meaningful and usable ratings (Lennard, 1962; Strupp, 1955; 1960; 1962). The Bales measure is selected because it is particularly useful in quantification of therapist's responses in that it:

(1) provides a general purpose framework for describing social interaction, (2) it is theoretically neutral with respect to different

conceptual approaches to psychotherapy, and (3) it provides a means of describing the attitudes and/or style of behavior by therapists toward clients. The Bales Categories are presented in Table 2.

The measure derived from Strupp's procedure, Type of Therapist Activity, is selected because it is well suited for assessing the degree to which therapists take responsibility for directing clients verbalizations (Strupp, 1960). This system is also particularly valid for comparisons between therapists of varying experience levels, degrees and kinds of training, backgrounds, and so on (Strupp, 1960). By use of this scale an attempt is being made to assess what kinds of therapeutic activity the therapist typically employs. Does he primarily ask questions, offer interpretive statements, give authoritative statements, give authoritative opinions, or rely on inferential operations? Thus the attribute identified by this Scale (see Table 3) is referred to as directiveness.

The content-analysis measure based on Lennard and Bernstein's work is designed to investigate the extent to which the therapist places limits upon the array of verbal responses from which the patient may choose a reply. The attributes, therefore, measured by this Scale (see Table 4) is identified by the term specificity, and is primarily associated with attempting to discover if therapists differ in how they may elicit information from their clients.

JUDGES

The author served as principal judge for this study, assigning all scorable therapist verbalizations into the various categories on

TABLE 2

Interaction Process Categories^a

<u>Category Number</u>	<u>Interaction Process Category</u>	<u>Psychotherapeutic Definition^b</u>
1	<u>Shows solidarity</u> , raises other's status, gives help, reward.	Gives reassurance, encouragement, shows compassion, empathy.
2	<u>Shows tension release</u> , jokes, laughs, shows satisfaction.	Expression of cheerfulness, bouyance, satisfaction, gratification, or any positive response conveying tension reduction.
3	<u>Agrees</u> , shows passive acceptance, understands, concurs, complies.	Shows passive acceptance, understanding, is permissive.
4	<u>Gives suggestion</u> , direction, implying autonomy for others.	Proposes course of action, defines (structures) situation.
5	<u>Gives orientation</u> , evaluation, analysis, expression of feelings or wishes.	Interprets, analyze behavior patterns, inferential reasoning, confrontations.
6	<u>Gives orientation</u> , information, repeats, clarifies, confirms.	Restates, clarifies, reflects.
7	<u>Asks for orientation</u> , information, repetition, confirmation.	Asks factual questions, expresses lack of knowledge, uncertainty.
8	<u>Asks for opinion</u> , evaluation, analysis, expression of feeling.	Explores, asks for elaboration or expression of feeling.
9	<u>Asks for suggestion</u> , direction, possible way of action.	Seeks solution through action of other as to how to proceed, etc.

(Table continued on next page)

Interaction Process Categories--Continued

<u>Category Number</u>	<u>Interaction Process Category</u>	<u>Psychotherapeutic Definition</u>
10	<u>Disagrees</u> , shows passive rejection, formality, withholds help.	Shows passive rejection, disbelief, ignores request or complaints.
11	<u>Shows tension</u> , asks for help, withdraws out of field.	Expression of personal discomfort.
12	<u>Shows antagonism</u> , deflates other's status, defends or asserts self.	Shows antagonism, aggression, sarcasm, irony, cynicism.

^aBased on a scale developed by Bales (1950).

^bThis column gives examples of kinds of responses by therapists included in the categories.

TABLE 3
Type of Therapist Activity^a

<u>Category</u>	<u>Type of Activity</u>	<u>Psychotherapeutic Definition</u>
1	Facilitation	Acceptance or acknowledgment of client's communication (e.g., "um . . . go on . . . I see . . .").
2	Exploration-Clarification	1) Simple questioning. Asking for further information, clarification, examples, elaboration; simple probes, broad case history questions (e.g., "What do you mean . . . ?" "For example?" "I don't understand." "Say that again."). 2) Reflection of feeling. 3) Restatement for clarification (e.g., "Did you mean that . . . ?" "By that you meant . . .).
3	Moderately inferential and/or Moderately interpretative	Questioning to stimulate client's curiosity and to stimulate self-exploration; suggestive summaries; pointing out inconsistencies. (e.g., "What do you make of that?" "Is there a connection between . . . ?" "That is why you are sad")
4	Direct Interpretation	Direct interpretation (analysis of defenses; establishing connections, identifying wishes or problem areas, direct confrontation).
5	Guidance	Guidance or direct instruction, either in reference to therapy or to situations outside of therapy. (e.g., "Why don't you")

^aAdapted from Strupp (1960).

TABLE 4

Specificity of Therapist Interventions^a

<u>Category</u>	<u>Type of Intervention</u>	<u>Psychotherapeutic Definition</u>
1	Encouragement to talk.	Passive or active encouragement to talk, without providing a subject matter or other limiting of client's choice of response. (e.g., "Um hum," "go-on," "Yes, I see.")
2	Limits to subject matter.	Client is limited to one subject area, but within that area can select from a wide range of information and frame of references. For example, "How do you feel about . . . (subject matter is provided or specific mention of subject is offered). "Tell me about" Statements usually beginning with "Why," "How," and "What," when a specific subject matter follows, are usually scored in this category.
3	Limits to proposition ^a or to specific idea.	Differs from #2 in referring to a specific idea or frame of reference to which the client <u>must</u> address himself. Hypotheses, interpretations, confrontations, and the like, are included in this category. For example, "How is it that you find your work too hard?" is scored in this category. "How do you feel about your work?" is scored in category 2. Statements of an interpretative nature ("You are afraid to go to work.") are included in category two.
4	Introduction of a new idea or proposition.	Differs from #3 in that statements in this category reflect the therapist taking initiative in introducing a new idea. Therapist attempts to stimulate client to react to new idea. Therapist offers

(Table continued on next page)

Specificity of Therapist Interventions--Continued

<u>Category</u>	<u>Type of Intervention</u>	<u>Psychotherapeutic Definition</u>
		alternative to client. (e.g., "You sound depressed" . . . "Maybe it's because" "Look at it this way")
5	Direct Interpretation (A sequence of new propositions.)	Therapist actively reorganizes informational propositions already conveyed, recombining them in a new way or different manner to attempt to <u>redirect</u> the client's way of perceiving, or to <u>redirect</u> the flow of subsequent information. A long sequence is usually offered, which usually distinguishes it from #3. (e.g., "I think that because you . . . you came to think of this as threatening and somehow to be avoided")
6	Limits to specific answer.	Content of expected answer is clear to client. Questions of fact. "Yes - No" questions. Therapist attempts to solicit a particular item of information.
7	Excludes discussion.	Therapist directs client's communications into a different channel and/or excludes a specific topic or communication. (e.g., "We need not go into that now" . . . "That's not important.")

^aAdapted from Lennard and Bernstein (1960).

^bA proposition is defined as a verbalization containing a subject and predicate either expressed or implied. It is the verbal expression of a single idea.

the three scales. In order to test reliability of these judgments, a second judge, who is an advanced clinical student, and who was not a subject in the study, independently evaluated a random sample of 600 statements to test accuracy of scoring. Typescripts were identified by code numbers. The two judges trained together in the use of these measures by evaluating typescripts (not those used in the study), until agreement was reached upon for criteria for scoring, and until a minimum of 15 successive statements were agreed upon. The criteria for scoring therapist interventions is described in Appendix B.

CHAPTER IV

RESULTS

RATER AGREEMENT

The two judges were in agreement for 82% of the statements (Type of Therapist Activity, 81%; Specificity of Therapist Interventions, 78%; Interaction Process Categories, 89%). These figures represent a relatively high degree of consistency in the scoring of therapist statements, and compare favorably with reliability figures in other investigations (see Holzman and Forman, 1966).

AMOUNT OF THERAPIST ACTIVITY

A total of 2,347 therapist interventions were obtained from the two therapy hours, from which 1,994 were scorable (see Appendix B for scoring criteria). A t -test between the mean number of statements for each therapy hour by each therapist (mean for the first hour is 59.8; mean for the second hour is 58.1), reveals no statistically significant differences between the number of statements for the two hours ($t = 1.05$, $df = 18$, $p > .10$). The rate of therapist activity, then, is consistent, between the two hours. A t -test between each of the therapist's average scale score on both the Specificity and Type of Activity Scales, reveals no significant differences in the nature of their

interventions between the two therapy hours (t for Specificity = 1.11, $p > .10$; t for Directiveness = .80 $p > .10$, $df = 18$). Comparison of the two hours on the Interaction Process Categories (t -tests between each of the 12 Categories for the two hours) shows no significant differences between the two hours in regard to the dimensions scored (t in each case resulting in less than 2.10, for attainment of significance at the .05 level). This relative consistency of therapist behavior over two therapy hours, separated by a minimum of two weeks, suggests that a representative sample of therapeutic activity has been obtained. Since the therapist's activity is generally consistent over the two hours, the activity during each hour has been combined, and the combined data analyzed as a representative sample of therapists' behavior.

In order to determine if there is a relationship between the amount of therapeutic activity and A-B Scale scores, a rank order correlation between these two variables was obtained. The resulting correlation of -.33 narrowly misses significance at the .05 level.

THERAPIST ATTITUDE

The Bales Social Interaction Process Categories (Table 2) was used to attempt to measure the relative proportion of therapist statements which were positive or negative reactions. According to Bales, the twelve separate categories which constitute the scale can be combined to form four sub-scales, each representing a different form of interaction. Categories 1-3 group together to identify positive reactions; categories 4-6 identify behavior described as giving orientation; categories 7-9 describe behavior which asks for orientation; and

items 10-12 describe negative reactions. It is the first and last sub-categories in which therapist attitude has its operational referents. The procedure followed was to code each therapist's statements into one of the 12 categories, collapse the scale into the four sub-groups, and convert the distribution of statements for each therapist into percentage indices. Each percentage figure represented then, the proportion out of the total number of statements offered for each therapist, of interventions in a given category. (This conversion to percentage indices was also applied to the data for the other two scales.) Table 5 shows the proportion of each therapist's scorable verbal output that falls under each of the four sub-scales described above, together with their A-B Scale scores. Means are also given for the overall group, and for the A and B groups. The A and B groups were constituted by a median split of the A-B Scale scores (median = 13.5).

Most of the therapeutic activity described by these four categories appears to be equally divided between giving orientation and asking for orientation. Positive type of interventions, those representing encouragement to talk or agreement with client, and negative statements, representative of disagreement, sarcasm, and aggression, are made less frequently than the above two types, but with positive statements offered with greater frequency than negative ones.

In order to determine the extent to which the distribution of scores within each category is related to therapist's A-B Scale scores, a rank order correlation was computed between A-B scores and each of the four categories. Table 6 presents the results of this analysis.

TABLE 5

A-B Scores and Proportion of Therapist Interventions in Each of
Four Sub-Scales of the Interaction Process Category Scale*

<u>Therapist</u>	<u>A-B Score</u>	<u>Positive Reaction</u>	<u>Gives Orientation</u>	<u>Asks for Orientation</u>	<u>Negative Reaction</u>
A	6	.15	.36	.47	.02
B	8	.15	.46	.37	.02
C	9	.26	.33	.40	.01
D	10	.11	.53	.35	.01
E	11	.13	.38	.47	.02
F	12	.14	.46	.39	.01
G	12	.03	.42	.51	.03
H	12	.09	.45	.42	.04
I	13	.05	.45	.49	.01
J	13	.20	.24	.36	.20
K	13	.20	.40	.33	.07
L	14	.21	.35	.36	.08
M	15	.16	.51	.32	.01
N	15	.17	.44	.35	.04
O	18	.11	.50	.31	.08
P	18	.04	.76	.19	.01
Q	18	.01	.54	.39	.05
R	18	.25	.30	.35	.10
S	19	.03	.45	.47	.05
T	19	.23	.46	.25	.06
Mean for all therapists:		.12	.43	.43	.04
Mean for A's:		.12	.48	.33	.05
Mean for B's:		.19	.41	.41	.04

*Appendix C (Table 11) contains the observed frequencies in each category.

TABLE 6

Rank Order Correlations Between A-B Scale Scores and Interaction
Process Categories

<u>Category</u>			
<u>Positive Reaction</u>	<u>Gives Orientation</u>	<u>Asks for Orientation</u>	<u>Negative Reaction</u>
-.07	.29	-.71*	.38**
* $p < .01$ ** $p < .06$			

The findings indicate: (1) a negative, but not significant correlation between the Positive Reaction category and A-B Scale scores, (2) a positive, but not significant, correlation between Gives Orientation type of statements and A-B scores, (3) a significant negative correlation between Asks for Orientation type of interventions and A-B Scale scores, and (4) a positive correlation between statements categorized as Negative Reactions and A-B Scale scores. This last rank order correlation of -.38 which attains significance at the .06 level is considered as an acceptance confidence limit for the purposes of this study. However, since it was derived from a category containing relatively small proportions, a One-Sample Runs Test (Siegel, 1956) was used to determine if the distribution of scores within this category may be due to chance. The result ($p < .05$) indicates that the scores obtained are acceptable as representative of therapeutic activity.

TYPE OF THERAPIST ACTIVITY

Table 7 shows the distribution of therapist statements in the five categories for type of responses together with the mean scale scores for each therapist. In order to determine the relationship between A-B Scale scores and type of therapeutic activity, a correlation coefficient was obtained between A-B scores and the mean scale scores for each therapist. The resulting correlation of .31, although not statistically significant, but nevertheless approaching significance ($p < .05 = .37$), indicates that the lower the A-B score, the tendency to be less direct, and the higher the A-B score, the tendency to be more direct.

In order to determine if there is any relationship between the proportion of statements made by A and B therapists within each category and A-B Scale scores, rank order correlations were derived between A-B scores and proportion of interventions within the five categories. Table 8 presents the results of this analysis.

TABLE 7

A-B Scores and Type of Therapeutic Activity: Proportion and Mean Scale Score of Therapist Interventions in Each of Five Categories^a

<u>Therapist</u>	<u>A-B Score</u>	<u>Categories*</u>					<u>Mean Scale Score</u>
		<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	
A	6	.14	.53	.20	.11	.02	2.33
B	8	.15	.43	.35	.07	.00	2.60
C	9	.28	.35	.28	.06	.03	2.24
D	10	.10	.38	.31	.20	.01	2.54
E	11	.11	.54	.26	.08	.01	2.34
F	12	.13	.34	.46	.07	.00	2.52
G	12	.16	.38	.30	.10	.06	2.47
H	12	.09	.26	.34	.30	.01	2.91
I	13	.06	.53	.34	.06	.01	2.42
J	13	.23	.51	.17	.07	.01	2.10
K	13	.16	.27	.30	.25	.02	2.70
L	14	.22	.51	.26	.11	.00	1.94
M	15	.18	.44	.26	.12	.00	2.34
N	15	.14	.36	.35	.14	.01	2.53
O	18	.10	.20	.44	.24	.02	3.58
P	18	.05	.38	.44	.13	.00	2.55
Q	18	.03	.33	.41	.20	.03	2.91
R	18	.24	.39	.13	.18	.06	2.30
S	19	.05	.41	.39	.11	.04	2.65
T	19	.21	.33	.25	.21	.00	2.48
<hr/>							
Mean for all							
Therapists:		.13	.42	.31	.13	.01	
Mean for A's:		.14	.37	.33	.16	.02	2.57
Mean for B's:		.16	.41	.30	.12	.01	2.47
<hr/>							
1* - Facilitation							
2 - Exploration							
3 - Moderately Interpretative							
4 - Direct Interpretation							
5 - Guidance							

Appendix C (Table 12) contains the observed frequencies within each category.

TABLE 8

Rank Order Correlations Between A-B Scale Scores and Type of
Therapist Activity

<u>Categories</u>				
<u>Facilitation</u>	<u>Exploration</u>	<u>Moderately Interpretative</u>	<u>Direct Interpretation</u>	<u>Guidance</u>
-.62*	-.25	.15	.38**	.08
*p .01				
**p .05				

Two significant correlations were obtained. The correlation of -.62 between A-B scores and facilitation indicates that therapists tend to differ in the extent to which they influence the content and/or direction of psychotherapy. B therapists apparently tend to offer more types of interventions along the lines of, "Um hum," "Go on," "Um," grunts, and the like, than A therapists.

The correlation of .38 between A-B scores and proportion of statements representative of direct interpretations indicates that A therapists are more actively engaged than B therapists in this type of therapeutic activity. In addition, the correlation of -.25 although not statistically significant, between exploratory activity and A-B scores, leads to the suggestion that B's are tending to be more exploratory (indirect) than A's (direct). The remaining two correlations between Moderately Interpretative, and Guidance, and A-B Scale scores indicate that little or no relationship exists between these type of activities and A-B Scale scores.

THERAPIST SPECIFICITY

Table 9 shows the percentage of each therapist's verbal output that falls into each category of informational stimulus value, together with the mean scale score for each therapist.

The most active category is the one representing questions which limit the client to addressing himself to a specific idea, such as responding to statements of inference, confrontations, moderate interpretations, etc. The emphasis is on providing some degree of structure for the client. The second most frequent type of activity the therapists engage in is in asking specific questions in which the content of the expected answer is clear to the client, that is, eliciting factual material. Statements reflective of excluding discussion, encouragement to talk, and introduction of new ideas, occur infrequently when scored on this scale. Statements in which the therapist limits the client to responding to a subject area, that is, asking questions about something about which the client is relatively free to explore his own ideas and behavior, and direct interpretative remarks, in which the therapist re-directs the client's thinking, constitute about equal proportions of total therapeutic activity.

A correlation of $-.17$ between A-B Scale scores and mean scale scores for each therapist, although not statistically significant, leads to the suggestion that the lower the position on the A-B continuum, the less limiting the type of interventions; and that the higher the position on the A-B distribution of scores, the tendency to impose more specificity, that is, to limit the choice of response available to the client.

TABLE 9

A-B Scores and Therapist Specificity: Proportion and Mean Scale Scores of Therapist Interventions in Each of Seven Categories^a

Therapist	A-B Score	Categories*							Mean Scale Score
		1	2	3	4	5	6	7	
A	6	.11	.13	.41	.01	.05	.28	.00	3.60
B	8	.06	.19	.31	.04	.20	.20	.00	3.80
C	9	.09	.18	.57	.01	.05	.09	.00	2.99
D	10	.09	.15	.45	.05	.18	.08	.00	3.30
E	11	.06	.15	.39	.01	.01	.37	.00	3.91
F	12	.16	.13	.55	.00	.09	.07	.00	2.63
G	12	.01	.17	.27	.02	.17	.29	.07	4.26
H	12	.05	.13	.32	.03	.31	.16	.00	3.91
I	13	.00	.19	.38	.01	.06	.36	.00	3.97
J	13	.10	.17	.30	.03	.00	.40	.00	3.87
K	13	.05	.17	.36	.00	.24	.17	.01	3.74
L	14	.08	.18	.43	.08	.01	.02	.00	3.34
M	15	.17	.12	.35	.09	.09	.18	.00	3.37
N	15	.09	.10	.43	.04	.15	.18	.01	3.62
O	18	.08	.13	.50	.03	.20	.05	.01	3.28
P	18	.02	.07	.62	.05	.11	.13	.00	3.54
Q	18	.00	.09	.66	.00	.05	.20	.00	3.64
R	18	.06	.11	.37	.01	.16	.28	.01	3.98
S	19	.04	.29	.43	.06	.12	.04	.02	3.11
T	19	.14	.09	.39	.02	.18	.18	.00	3.57
Mean for all therapists:		.07	.15	.42	.03	.12	.20	.01	
Mean for A's:		.07	.13	.46	.04	.12	.14	.01	3.50
Mean for B's:		.07	.16	.39	.02	.12	.22	.01	3.63

1* - Encouragement to talk.

2 - Limits to subject matter.

3 - Limits to proposition or to specific idea.

4 - Introduction of a new idea or proposition.

5 - Direct interpretation.

6 - Limits to specific answer.

7 - Excludes discussion.

^aAppendix C (Table 13) contains the observed frequencies in each category.

Rank order correlations between A-B Scale scores and each of the specificity categories are presented in Table 10.

TABLE 10

Rank Order Correlations Between A-B Scale Scores and
Specificity of Therapist Statements

<u>Categories*</u>						
<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>
-.54*	-.29	.07	.26	.13	-.11	.01
*p < .01						

-
- 1* - Encouragement to talk.
 - 2 - Limits to subject matter.
 - 3 - Limits to proposition or to specific idea.
 - 4 - Introduction of a new idea or proposition.
 - 5 - Direct interpretation.
 - 6 - Limits to specific answer.
 - 7 - Excludes discussion.
-

The findings indicate a significant negative relationship between A-B Scale scores and Encouragement to talk, indicating that B therapists are tending to be more actively engaged in this type of behavior than A-therapists. The remainder of the correlations reveal: (1) a negative, but not significant, relationship between Category 2 and A-B scores, (2) an insignificant correlation between Category 3 and A-B scores, (3) a positive, but not significant, relationship between Category 4 and A-B Scale scores, and (4) no significant correlations between Categories 5, 6, and 7, and A-B Scale scores.

In order to illustrate the differences in therapeutic activity of A- and B-type therapists, several excerpts of therapist communica-

tions are cited below. These excerpts are from those therapists who scored high on the A-B scale (A therapists), and from those who scored low (B therapists). In parenthesis beside each statement are the categories assigned to it on each of the three scales. Listed first is Type of Therapeutic Activity, followed by the Specificity category, and then by the category on the Interaction Process Scale. The statements are listed in the order in which they occurred during the therapy hour.

Therapist 0, A-B score 18 (Hour #1)

1. Tell me some about that, B. (2, 2, 4)
2. No. (Not scorable (N.S.), N.S., 10)
3. Well, I'm not sure I'm always angry when you think I'm angry. There are times when you have described something, described an incident that you have experienced and the way you feel about yourself . . . and I said something like it sounds like you feel like a real "clod." And then you come back and say, "You called me a clod," and then, uh, . . . it seems to me that often when I really reflect what you already said about yourself you experience me as being highly critical. (4, 5, 5)
4. (Not audible)
5. (Interrupts client) There are other times when I clearly have been irritated . . . uh . . . angry about the way you've behaved in here, but I've been clear and open about that . . . and how it hasn't been put on. (4, 4, 5)
7. You know, I don't see myself as jumping on you for bringing up things, B., but I do and I tell you when I do become irritated at the way you at times try to relate to me. And as I've told you I think that anyone would. You complain about the way people react to you and I honestly tell you that the way you interact with me at times would bring anyone, would cause anyone to become irritated with you and to treat you the way that you don't like to be treated. (4, 5, 5)
8. This becomes the characteristic way that you react. (4, 5, 5)
9. You may be able to find some better alternatives. (3, 4, 5)
10. I don't know what we've anything to gain, B., by trying to figure

out just what all is behind it. Why don't you just forget about trying to figure it out right now, and talk about what is important to you, aside from the figuring out. (5, 7, 4)

As can be observed this therapist's interventions are not only lengthy, but they also tend to be quite direct. This sequence also occurs early in the hour. As the hour progresses, the nature of his therapeutic activity does not appear to change much.

24. Yeah. At a point when we were talking about five or six years of psychotherapy and what you might be able to hope for. I'm not saying you ought to do that right at this moment, and I've clarified that numerous times . . . I . . . my only point in reacting when you continually jump back to the day your parents called you in and said something to you, and the day the maid called you in and said something to you, is that, yeah, these things happen and they sure as hell affect you, the way you feel about yourself. And, yet, each time you start talking about what's going on in here, ah, you jump back to that as if to say "It can't be any different because that happened." (4, 5, 5)
25. Yeah. And I feel that you're there, but you're not a teenager now. And that didn't happen yesterday, and maybe in the interactions that you find yourself in now you do have some other alternatives. And what I'm saying is that at some level I think you're choosing the alternatives that you find yourself taking.
26. (Interrupts client.) And you're uncomfortable with the way people perceive you, and yet I think you're giving them little choice other than to perceive you in the way they do. (4, 5, 5)
39. I imagine you do feel bad. It must be hell living in a world full of nasty people that just go around jumping on you all the goddamn time. (3, 5, 5)
40. Must be a pretty special thought . . . everybody breaks into whatever they're thinking about the minute you walk by and start thinking about you, talking about you. (3, 5, 5).
41. I'm just reflecting what I think you're saying, "I walk by and people start talking about me." (3, n.s., 6)
42. That still makes you pretty special. To be so bad that whatever people are eating, whatever they're thinking, whatever they're talking about, they immediately stop and start talking about you. (4, 5, 5)

63. Yeah. What I'm saying, and what I'm obviously going to some pretty ridiculous extremes to drop . . . is . . . Goddamn B. At, 90% of this at least is going on in you, and yet you continually talk as if it's not going on in you but going on out there. And I say why is it going on out there? You say because the maid told me that I was good looking, both people are being critical of me. And what kind of dog shit is that? Because the maid told you you were good looking . . . and called you many other things you think they drop their knives and forks and spoons when you walk through the room. (4, 5, 5)
64. As I've said I think you were self-conscious from the word "go" . . . as far back as you've told me about yourself . . . way back to the first grade you were self-conscious . . . you were fearful. (4, 5, 5)
65. B., from what you say it sounds to me like the feelings that you've always had began to crystalize into some kind of awareness at about 14. But I just can't go along with you that it all started at 14 because of these two or three things that you tell me that happened. (4, 5, 5)
83. It seems you're the one who insists on being unusual or different and an extreme case. (4, 5, 5)
84. Let's see. You don't have any social graces. You're dumb. Uh, kinda successful sex life. You have . . . (n.s., n.s., 12)
85. Trouble on the job. (2, 3, 6)
94. We were talking about a specific kind of thing that goes between you and I, where at one moment we're talking about the way you feel now, and I say what do you make of it, what was going on then, and you jump back to the past, and say you couldn't ever talk about the past. (4, 5, 5)
95. The way you describe it it doesn't sound like much fun. (3, 3, 5)
96. Well, our time's up today, B. (n.s.)

In contrast to this highly direct manner of the above A-type therapist, excerpts from a B-type therapist show much less intensity and a much more relaxed manner of interacting.

Therapist A, A-B score, 16 (Hour #2)

The beginning of the hour involves discussion over the client having replaced broken glasses, after which the following took place:

24. Why? (2, 2, 7)
25. What bothered you? (2, 2, 7)
26. How does it belong to you? (2, 3, 7)
27. What do you mean? (2, 2, 7)
28. What things? (2, 6, 7)
29. (Not clear)
30. Just now. It's a cloud which follows me wherever I go. (2, 2, 7)
31. What? (2, 6, 7)
32. (Not clear)
33. Oh, for the same reason . . . (Not clear) . . . (n.s.)
34. Dodge, did you say? (2, 6, 7)
35. What did you want me to say? (2, 3, 6)
36. Or mystical? (2, 3, 6)
37. It's just mystifying. (3, 3, 5)
38. Um hum. (1, 1, 3)
39. Well, it sounds better than the other one. It sounds like you're to narrow the gap between you and M., or come to terms with him in a positive way. (4, 5, 5)
57. What brought all this shifting about? Or is it just Saturday morning or what? (2, 2, 7)
58. What brought it about? (2, 2, 7)
59. Aha. And its . . . (n.s.)
60. Somehow somethings just not worth it. The Romanticism or something . . . (3, 3, 3)

61. I feel like you said to yourself, you know, how maybe it's getting or something to take effect. Have you? (3, 3, 5)
62. You said this was brought about by B's having the baby and then you mentioned that you were envious earlier in the hour. Only I wonder if your feelings maybe it's getting late for you. (4, 5, 5)
63. Told anybody what? (2, 6, 7)
64. Um hum. (1, 1, 3)
65. Why? (2, 2, 7)
66. Hum. That was the night I did call up, huh? (2, 6, 7)
67. Not clear. (n.s.)
68. Well, I wonder what's going on. Sounds like something's bothering you. Then you say you've worked everything out, you're a pragmatist. I'm not sure that it's all worked out that neatly. (4, 5, 5)
95. What? (2, 6, 7)
96. Um hum. (1, 1, 3)
97. (Not clear)
98. Um hum. (1, 1, 3)

The differences between the styles of therapeutic activity of these two therapists is apparent. Excerpts from another B-therapist reveals a similar type of activity as the B-therapist cited above.

Therapist B, A-B score 8 (Hour #2)

Statements representative of early and late in the hour.

1. Go on. (1, 1, 1)
2. You don't talk well? (2, 2, 6)
3. How's your voice this morning? (2, 6, 7)
4. You said that this morning. Then you began comparing notes on therapists. (3, 3, 3)

5. But, I'm wondering what happened between last night when you almost had a run-in, almost had a quarrel, I guess you did have a run-in whatever that is . . . and then this morning you being here with some fraternity, huh. (3, 5, 5)
6. That you didn't want. (2, 2, 6)
7. That you didn't want. (2, 2, 6)
8. Laughs. (1, n.s., 2)
9. Well, there's evidently something you were going to say for several minutes. (2, 2, 5)
10. Loudly chomping? (2, 2, 6)
11. How's work? (2, 6, 7)
12. Well, of course, I ask because I'm wondering what kind of things were going with you when you came home very, very tired and you worked the night before. (2, 2, 7)
13. Yesterday evening and today. I'm wondering what was, if you hadn't set yourself up for whatever you called it. (3, 3, 5)
14. What's pissing you off now? (2, 2, 7)
15. Um hum. (1, 1, 3)
36. Because he wants to kiss you on the lips? (3, 3, 7)
37. Are you? (2, 2, 7)
38. I can't help but feel that an 11 year old boy, who has enough affection for his father that he wants to kiss him can mean that you've put too big a wall between you. But you're working at it. old buddy! (4, 5, 5)
39. You know that all the popcorn eating and being kissed on the lips by your son has to do with loneliness and isolation, huh. (3, 3, 5)
40. Well, you know I think the game bit is whether or not you can afford to give up some of that loneliness for some of J. really is. I'm talking about the pain of recognition of dependency and finiteness. (4, 5, 5)
41. That you're not going to go on forever. (3, 3, 5)
42. Is she? Continuing to see B." (2, 6, 7)
43. Um hum. (1, 1, 3)

44. Um hum. (1, 1, 3)

45. I'll see you next Saturday. (n.s.)

Clearly, therapists A and B both differ from therapist O. The next excerpts are from another therapist on the A-end of the A-B scores. Although his statements are briefer than therapist O's, sarcasm is evident.

Therapist R, A-B score 18 (Hour #2)

12. You're saying your wicked. No rest for the wicked. (4, 3, 5)

13. You'll get used to the machine. Just forget it. (5, 7, 4)

14. You will. (5, n.s., 4)

15. I think I heard some of the propaganda, yeah. (1, n.s., 3)

16. Well, you've gone from one end of the east coast to the other in about five minutes here. (4, 3, 5)

37. Play them on the radio, network if possible. (n.s., n.s., 10)

38. We have a contest called therapist of the week. The best tape gets to be played on the radio. Besides that you get five dollars worth of Nash-Rambler windshield wipers. (n.s., n.s., 12)

39. You go to a national contest, you know. The winner of that gets a liquid latex sports coat. (n.s., n.s., 12)

40. Umm - no. (n.s., n.s., 10)

41. Oh yeah. (1, n.s., 3)

42. Writing it? (2, 6, 7)

43. What's it mean to you? (2, 2, 8)

58. Liquid latex. Why did you think of Battle Creek? (2, 6, 7)

59. What is it? (2, 6, 7)

60. Does he have any real talent? (2, 6, 7)

61. That's a handicap. (n.s., n.s., 5)

- 62. What's he draw, sketch, paint, whatever? (2, 6, 7)
- 63. He was the young one, wasn't he? (2, 6, 7)

Excerpts from another A therapist also illustrates the same intensity in therapeutic activity as demonstrated by therapist O.

Therapist P, A-B score 18 (Hour #2)

- 25. That's the feeling I get. That you're talking about perhaps its somebody else out there and lets not really talk about you. But what's supposed to be or not supposed to be from somebody elses' standpoint or view? (4, 5, 5)
- 26. Sort of a way to talk about it without being too threatened. (3, 3, 5)
- 27. If we could put it off and talk about somebody else and how they think it should or should not be. (3, 3, 5)
- 28. It's kinda frightening to think about oneself sometimes, isn't it? (3, 3, 5)
- 29. Sort of gets confused between the way other people think it should be and the way you really feel. (3, 3, 5)
- 30. I don't think I could give you a straight forward answer. I think its often easier to know the should's or should not's that others have taught us, more than it is ourself because in some ways we seem to try to live up to the should not's or should's and therefore, really hide it from ourselves. In a sense I think by this we lose what we really feel and let out only what others should or should not hear. That's the feeling I've had here, that much of what you said, has been said, with the thought of approval. Whether he apporves or disapproves of certain things. (4, 5, 5)
- 31. It's also threatening to oneself, isn't it? (3, 4, 7)
- 32. Or it's kinda hard to put into words. (3, 3, 7)
- 33. Well then, just let it fly. You know, whether there's any logical connection to it or not. (1, 2, 4)
- 34. Sort of a shell we build for ourselves to protect ourselves from things we don't like about ourselves or feelings that we have that we don't quite understand. (4, 5, 5)
- 35. It's not an easy thing. Cause it really goes contrary to the things we do in ordinary life. It won't always be the most com-

fortable either, I don't think. (4, 5, 5)

The contrast in another B therapist is apparent.

Therapist C, A-B score 9 (Hour #1)

2. Is that fun? (2, 6, 7)
3. How's that? (2, 6, 7)
4. By yourself? (2, 2, 7)
5. If going back home makes you feel that miserable, why do you go?
(3, 3, 7)
6. Doesn't sound like Dad is your very good tension reliever. (3, 3, 5)
7. But you keep trying. (3, 3, 5)
8. Don't know. (n.s., n.s., 10)
9. I'm not sure For his approval, maybe? (3, 3, 5)
10. What do you mean? (2, 2, 7)
11. Oh! (1, n.s., 3)
12. Don't suppose there's much you can do about it. (3, 3, 7)
13. You have to? (2, 3, 7)
14. What's that? (2, 6, 7)
15. Oh. (1, n.s., 3)
16. Laughs. (1, n.s., 2)
17. I believe you. (n.s., n.s., 3)
18. Somehow you can't get away from him, huh? (3, 3, 5)
19. Why? (2, 2, 7)
20. Sounds to me like you're being pretty damn hard on yourself. (4,
3, 5)
33. Laughs. (1, n.s., 2)
34. Yeah, I believe you. (n.s., n.s., 3)

35. Why should they have ended up all hating you? (2, 3, 7)
36. How'd you go about becoming a dirty rat? (2, 3, 7)
37. You were successful. Or maybe you did feel that way? (3, 7, 8)
38. Successful. (n.s.)
39. What's paranoid mean? (2, 3, 7)
40. Um. (1, 1, 3)
41. Maybe she's fond of you? (3, 3, 5)
42. Well. (1, n.s., n.s.)
43. Maybe she'll get out of your life. (3, 3, 5)
44. See you later. (n.s.)

CHAPTER V

DISCUSSION

The results of this study indicate that there is a relationship between the A-B Scale scores of therapists and aspects of their behavior in a psychotherapeutic relationship with non-psychotic clients. Specifically, one of the findings indicates that those therapists on the lower end of the A-B Scale score distribution tended to make fewer statements classified as "negative" than those on the upper end of the distribution. Thus, the frequency of negative type of remarks (aggressive comments, sarcasm, cynicism, antagonism, and so on), appears to be more representative of A-type therapists than B-type therapists.

A second finding that A and B therapists tend to differ to the extent to which they influence the content of therapy. B therapists were found to be more facilitative, that is, to encourage clients to express themselves, rather than to provide answers or offer interpretations to them. The A therapists, in contrast to B's, tended to engage more frequently in inferential operations, that is, to offer interpretative type statements. Thus, B's apparently tend to leave the content and direction of therapy more to their clients than A's; while A's tend to take greater initiative for structuring the relationship by offering more interpretative statements, authoritative opinions, and the like.

Additional results tend to complement and support the above findings. If A and B therapists differ to the degree to which they are direct (interpretative) and indirect (facilitative), then it would be expected that these differences would also be reflected in the Gives Orientation and Asks for Orientation categories on the Interaction Process Scale. Such a finding was obtained. The significant negative rank order correlation of $-.71$, between asks for orientation and A-B Scale scores, indicates that B's are more actively engaged in asking for elaboration from their clients and having them respond from their own frame of reference. If such is the case, then it would also be expected that A's would tend to give orientation, that is provide a frame of reference for their clients, to a greater extent than B therapists. Although the correlation between the category of Gives Orientation and A-B Scale scores is not significant ($.29$), it is in the predicted direction.

The third finding, which is consistent with the ones described above, is that B therapists tended to place fewer restrictions upon the array of verbal responses from which a client may choose a reply, than did A therapists. Specifically, B therapists were more actively engaged in attempting to have clients follow their own trend of thought, and in asking less specific type of questions, than A therapists.

The overall results are summarized as follows: A therapists tend to provide clients with information or a frame of reference which may help to increase their understanding of themselves and the world around them; B therapists tend to require clients to provide information or a frame of reference from within themselves to help achieve

self-awareness. Further, the interventions of B's are less frequently negative than the interventions of A-therapists. Thus, it appears that A- and B-type therapists tend to afford different kinds of therapeutic experiences to their clients.

The findings from previous studies with the A-B Scale pose one very basic question: Why are some therapists better than others? That is, why are A's apparently more successful in treating schizophrenic patients and B's more successful with neurotic patients? The results of this investigation suggest some answers, at least with regard to the treatment of neurotic clients. These findings suggest the hypothesis that for the neurotic person a facilitatory type of therapeutic experience may be a more effective means of stimulating changes in personality. In addition, the attitude of B therapists, who apparently refrain from negative type of responses to a greater extent than A's, may create a therapeutic climate more conducive to the achievement of self-awareness on the part of the client. This refraining from negative responses is in keeping with the notions of Fiedler (1950; 1950a; 1953), and others, that the therapist's acceptance, warmth, empathy, and understanding, are important factors and "effective elements" which lead to personality change. Interestingly, however, no differences were found between A's and B's in regard to the frequency of positive type of statements. This finding leads to the speculation that it may be differences in the frequency of statements conveying warmth between therapists which partially accounts for successful treatment, but that possibly the absence of critical or negative comments may be a crucial factor which is related to the nature of therapeutic outcome. The important

question, however, as to why A's are more effective and B's less effective in treating schizophrenic patients remains unanswered. To answer this question, a factorial design is needed in which A-and B-therapists are each treating a neurotic and a schizophrenic individual. Due to the absence of schizophrenic individuals at the clinic where this research was conducted, this ideal design was not possible. This approach is a next logical approach in A-B research.

The findings from this study differ in one respect from previous literature concerning the A-B Scale. Prior studies have indicated that B's tended to evaluate neurotic persons negatively. The present results indicate that B's are apparently not manifesting negative attitudes to the same extent to which A's do. A-therapists were the ones who gave negative type interventions more frequently. It would be of interest to determine in further studies if differences exist between the attitude therapists express toward clients, and the nature of their behavior in therapy toward these clients. That is, would there be a difference between the way therapists feel and act toward clients? In addition, since this study did not focus on behavioral differences of therapists which may be associated with the sex of clients, it might be of interest in future research to explore this area.

The finding that there is a relationship between therapist's scores on the A-B Scale and aspects of therapeutic activity is particularly striking in that it has been obtained from a homogeneous group of therapists, whose level of experience is equally distributed. Since all therapists are from the same training program and apparently have

a similar orientation to therapy, the differences observed between A and B therapists apparently are superimposed over basically similar therapeutic philosophies. This result once again indicates that the A-B Scale measures some aspect of personality which is associated with different styles of therapeutic activity of A and B therapists. These differences in behavior styles are confirmative of previous hypotheses that suggest that the personality characteristics of the therapist can influence the process of psychotherapy (Fromm-Reichman, 1950; Strupp, 1960; Sullivan, 1953; Taft, 1933).

The results from this research serve to generate some pressing research questions. First, what is the effect on clients of these different kinds of therapeutic activity? (Some hypotheses have been suggested above.) One might speculate that the more limiting, focusing, or directive the therapist's comments are, the less the opportunity for the client to explore himself from his own frame of reference; and that neurotic or non-psychotic persons in a psychotherapeutic relationship achieve positive personality changes when interacting with a therapist who encourages self exploration. Furthermore, it would seem important that this self-exploration is not met with negative reactions. For this kind of person, changes in behavior may be the result or a function of being able to express themselves and to have the experience of sharing their feelings with an accepting therapist. These same type of persons may not be able to have the same kind of experience with a therapist who provides solutions and places less emphasis on having the client work toward achievement of self-awareness. Perhaps the important factor in therapy with neurotic persons is the

ability to bring unconscious material to awareness by being able to share one's thoughts and feelings with the therapist, rather than having to integrate knowledge about oneself acquired through interpretative summaries. Whether these same conditions apply to psychotherapy with schizophrenic patients, or if A-therapists afford these persons a facilitating kind of experience more readily than B's, needs to be investigated.

Secondly, research is also needed to determine the extent to which the types of therapeutic activity assessed in this study is characteristic of psychotherapists training in other centers. The A-B Scale research thus far has found relatively consistent finding A-B differences, which suggest that the results of this study may be tentatively generalized.

The A-B Scale has been shown to be an instrument which is correlated with events occurring in psychotherapy. As such it becomes a research tool of considerable importance. Until recently, psychotherapy research has followed the practice of assigning some persons to a "psychotherapy" group, with the assumption that the therapists were "standard" and homogeneous, and others to a "control" group. The results of such practice has contributed relatively little toward understanding the process of psychotherapy. With the use of the A-B Scale, however, it now becomes possible to identify and measure some of the therapist (personality) variables relevant to outcome, and to build them into experimental designs. When a design incorporates relevant patient variables and crucial therapist dimensions, the researchers can assess which therapist behaviors are more effective with which type of

patients. The A-B Scale not only shows promise of being a device to help discover some of the parameters needed to fill in a meaningful paradigm for psychotherapy, but also promise as a simple clinical tool to perhaps help match different type of patients to therapists who can work effectively with them to help insure a successful outcome.

CHAPTER VI

SUMMARY AND CONCLUSION

Research in psychotherapy has been hampered for a long time by (1) the lack of a conceptual model of the effect of the therapist's personality on the process of psychotherapy, and (2) by the lack of a research instrument with which to explore this area. Consequently, scientific knowledge has suffered because of the inability to identify therapist variables affecting the therapeutic process. More recently, however, with the growing awareness that the therapist, as a unique individual, exerts influence on the process of psychotherapy, interest has centered on attempting to explore the relationship between therapist personality variables and behavior in psychotherapy. An important contribution of empirical research findings identifying therapist personality variables has been obtained with the use of the Whitehorn-Betz A-B Scale.

A review of the literature dealing with the A-B Scale has shown that it measures general personality attributes which are of considerable significance in the psychotherapy of persons presenting differing forms of behavior disorders (neurotic vs. schizophrenic behavior). Specifically, it has been shown that the quality of the experience afforded the patient by an "A" or "B" type therapist is different,

and is probably determined by the interaction of the patient's personality and the personality of the therapist. In view of the consistent findings with the A-B Scale of differences in the behavior of "A" and "B" persons, further research with the A-B Scale is warranted.

Since much of the research with the A-B Scale thus far has been conducted in psychotherapy analogue studies involving "quasi-therapists" who had no professional training, research is needed to determine how correlates of the A-B Scale would be manifested in actual psychotherapeutic encounters. If it could be demonstrated that there is a relationship between the A-B dimension and the nature of the therapeutic experience afforded by A and B therapists, then an important advance would be made in identifying "therapist variables" for future research, and in contributing toward a further understanding of the therapy process.

Since previous research with the A-B Scale indicated that A's and B's interact differently when matched with neurotic or schizoid persons, this study attempted to determine if these two "types" of therapists would respond differently when interacting with a similar type client (those presenting neurotic symptomatology). Three specific areas of therapeutic behavior were investigated: (1) attitude toward clients, as manifested by their verbalizations, (2) type of therapeutic activity (questioning vs. interpretative summaries), and (3) specificity of statements (the degree to which therapist's statements set limits on how clients can respond). Therapist verbalizations were assessed by means of a content analysis system designed to categorize therapist's communications into three basic types of

activity: (1) type of activity (direct vs. indirect), (2) specificity, the degree to which therapists limit client's responses, and (3) type of interaction - positive vs. negative communications.

Subjects were 20 graduate students training in a clinical psychology program in interaction with one of their respective clients who most closely fulfilled the criteria of neurotic symptomatology. Tape recordings of two therapy hours were obtained for evaluation.

The analysis of therapist verbalizations indicated that there is a relationship between A-B Scale scores of therapists and therapeutic activity. Specifically, it was found that: (1) B-type therapists tended to make fewer negative type comments than A-therapists, (2) B-therapists were more facilitative, that is, encouraging of self-exploration, (3) A-therapists tended to be more interpretative, and (4) B-therapists tended to place less emphasis than A-therapists on having clients respond to specific questions or ideas. These findings are confirmative of previous research with the A-B Scale which suggested that there is a relationship between A-B personality characteristics and behavior in psychotherapy.

It may be concluded from the findings of this study that the A-B Scale measures some general personality attributes, and that these attributes are related to behavior in psychotherapy. Consequently, it appears that further investigation of A-B personality correlates and how they are manifested in a psychotherapeutic relationship would further the understanding of the relationship between the therapist's

personality characteristics and modes of behavior in therapeutic interactions.

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Appendix A

Client's Symptomatic Behavior Inventory

CLIENT'S SYMPTOMATIC BEHAVIOR INVENTORY

Name of Patient _____ Sex _____ Age _____

Time of Treatment: _____ Education _____ Therapist _____

INSTRUCTIONS: This inventory consists of a number of symptoms often manifested in emotional disorders. Read each and decide if it applies to your client or not. Indicate so by circling the true (T) or not true (NT) column by each item. Please answer every item. Thank you for your co-operation.

-
- | | | |
|--|---|----|
| 1. Patient is nervous most of the time | T | NT |
| 2. Expresses bizarre ideas | T | NT |
| 3. Has loss of appetite | T | NT |
| 4. Has difficulty sleeping - complains of insomnia | T | NT |
| 5. Has made a suicidal attempt | T | NT |
| 6. Is withdrawn | T | NT |
| 7. Complains of headaches | T | NT |
| 8. Is depressed | T | NT |
| 9. Talks of suicide | T | NT |
| 10. Feels perverted | T | NT |
| 11. Has hallucinations | T | NT |
| 12. Is perplexed most of the time | T | NT |
| 13. Is tense most of the time | T | NT |
| 14. Has a tendency toward compulsions | T | NT |
| 15. Makes self-deprecating statements | T | NT |
| 16. Is suspicious | T | NT |
| 17. Is apathetic | T | NT |
| 18. Is sexually preoccupied | T | NT |
| 19. Expresses bodily complaints | T | NT |

Appendix B

Criteria for Scoring Therapist Interventions

CRITERIA FOR SCORING THERAPIST INTERVENTIONS

Method for Assessment of Therapist's Verbalizations

Described below is the framework for categorization of therapist's verbalizations used in this study. It is based principally on the rules established by Lennard and Bernstein (1960) in their study. The same rules or procedures have been used by both Bales and Strupp in their investigation. Therefore, the system described below pertains to all three of the scales used in this study.

Proposition

A proposition is defined as a verbalization containing a subject and a predicate either expressed or implied. It is the verbal expression of a single idea. The following are rules for arriving at a proposition: (A) A proposition, in this study, will consist of an independent clause together with one or more dependent clauses. When a single subject is followed by a series of predicates a separate score is not to be given for each predicate. Instead, the entire verbalization will be scored as one unit. For example, the statement, "This problem, which you talked about yesterday is a very difficult one for you, and one which you find beyond your powers to solve at this time," although containing a dependent clause, is to be counted as a single proposition - the assumption being that the whole meaning conveys more than the dependent clause standing alone. When a series of uninterrupted propositions, referred to as a therapist's statement, is offered the statement in its entirety, and not the individual propositions, will be scored. For example, the statement "It seems that you find it pleasing. It wasn't

always like that." is to be treated as one unit and scored for its total meaning. This procedure differs from that established by Lennard and Bernstein. The assumption underlying this approach is that the individual propositions are not unrelated, and that the total communication is to what the client is most likely to respond. (B) "Uh-huh," "Yes," "Mm-hm," etc. are counted as single propositions. (C) False starts do not count as separate units. The following sentence contains a single proposition: "I went, I went downtown yesterday." (D) Phrases like "You know," "I guess," "Well," "Huh," and "Isn't it," when added on to a sentence are not considered separate units. For example, "Well, you know, it may be very painful for you, huh?" The addition of "huh" apparently serves to form a question, rather than to leave the statement as a declarative remark.

Verbalizations

A therapist's verbalization is defined as a statement made by him immediately after a client's statement. Anything expressed by the therapist in response to client's verbalization is regarded as a message to his client, and categorized as its possible therapeutic import.

Incomplete Propositions

Utterances lacking some essential feature of a complete sentence because of an interruption by the client or a lapsing into silence are considered separate units whenever the meaning is clear. When not enough is said to make the meaning clear what is said is not considered to be scorable.

Appendix C

Observed Frequencies within Categories on Each of the Three Measures of Therapeutic Intervention

TABLE 11

A-B Scores and Frequency of Therapist Interventions in Each of
Four Sub-Scales of the Interaction Process Category Scale

<u>Therapist</u>	<u>A-B Score</u>	<u>Positive Reaction</u>	<u>Gives Orientation</u>	<u>Asks for Orientation</u>	<u>Negative Reaction</u>
A	6	23	53	70	3
B	8	13	41	33	2
C	9	22	28	34	2
D	10	19	95	62	3
E	11	22	64	79	4
F	12	10	33	28	1
G	12	2	30	37	2
H	12	7	33	31	3
I	13	10	92	99	2
J	13	10	12	18	10
K	13	18	37	30	7
L	14	19	32	33	7
M	15	13	43	27	1
N	15	14	36	29	3
O	18	18	78	48	13
P	18	3	53	13	1
Q	18	1	22	16	2
R	18	31	38	43	13
S	19	2	26	27	3
T	19	12	24	13	3

TABLE 12

A-B Scores and Type of Therapeutic Activity: Frequency of Therapist Interventions in Each of Five Categories

<u>Therapist</u>	<u>A-B Score</u>	<u>Categories*</u>				
		<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
A	6	22	80	31	16	3
B	8	11	31	25	5	0
C	9	24	30	24	5	3
D	10	17	68	54	35	3
E	11	17	86	41	13	2
F	12	9	24	32	5	0
G	12	11	26	20	7	4
H	12	6	18	24	21	1
I	13	12	108	70	12	1
J	13	9	21	7	3	1
K	13	13	23	25	21	2
L	14	19	43	22	1	0
M	15	15	37	22	11	0
N	15	11	29	28	11	2
O	18	13	26	59	32	3
P	18	4	30	34	10	0
Q	18	1	13	16	8	1
R	18	25	41	14	19	6
S	19	3	23	22	6	2
T	19	10	16	12	10	0

- *1 - Facilitation
 2 - Exploration
 3 - Moderately Interpretative
 4 - Direct Interpretation
 5 - Guidance

TABLE 13

A-B Scores and Therapist Specificity: Frequency of Therapist Interventions in Each of Seven Categories

<u>Therapist</u>	<u>A-B Score</u>	<u>Categories*</u>						
		<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>
A	6	15	17	54	1	7	37	0
B	8	4	14	23	3	15	15	0
C	9	6	12	37	1	3	6	0
D	10	16	25	77	9	30	13	0
E	11	9	21	55	2	2	52	0
F	12	9	7	30	0	5	4	0
G	12	1	10	16	1	10	17	4
H	12	3	8	20	2	19	10	0
I	13	1	34	68	4	11	61	0
J	13	3	5	9	1	0	12	0
K	13	4	13	27	0	18	12	1
L	14	5	11	26	5	1	12	0
M	15	13	9	28	7	7	14	0
N	15	6	7	29	3	10	12	1
O	18	11	17	67	4	26	6	2
P	18	2	5	47	4	8	10	0
Q	18	0	3	23	0	2	7	0
R	18	5	9	29	1	13	22	1
S	19	2	15	22	3	6	2	1
T	19	6	4	17	1	8	8	0

*1 - Encouragement to talk.

2 - Limits to subject matter.

3 - Limits to proposition or to specific idea.

4 - Introduction of a new idea or proposition.

5 - Direct Interpretation.

6 - Limits to specific answer.

7 - Excludes discussion.